Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective May15, 2025 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Ambulatory External and Implantable Electrocardiographic Monitoring - (0547)	Updated	Minor **changes** in coverage criteria/policy: • Updated the not covered policy statement for both Adult and Children Implantable monitor • Removed codes not implemented/managed
Atrial Fibrillation: Nonpharmacological Treatments - (0469)	Updated	Minor **changes** in coverage criteria/policy: • Removed content for atrial flutter as it is now addressed in CP 0529 Transcatheter Ablation for the Treatment of Supraventricular Tachycardia in Adults.
Balloon Sinus Ostial Dilation for Chronic Sinusitis and	Updated	Expanded coverage by making coverage criteria statements less restrictive. • Balloon Sinus Ostial Dilation: Removed measurement requirement for mucosal thickness.

Eustachian Tube Dilation - (0480)		• Balloon Sinus Ostial Dilation: Removed need for trial on two separate antibiotics • Eustachian Tube Dilation: Allowed for use of nasal topical spray (which includes antihistamines and/or steroids) instead of steroid only.
Bone Growth Stimulators: Electrical (Invasive), Ultrasound - (0084)	Updated	Minor changes in coverage criteria • Minor change: replacing the word "smoking" with "nicotine dependence" as one of the co-morbidities that delay wound healing
Circumcision - (0582)	New	New CP. • CPT 54161: Circumcision, surgical excision other than clamp, device, or dorsal slit; **older than 28 days of age**
External Counterpulsation - (0058)	Updated	Important **changes** in coverage criteria Posting date 5/15/2025, effective date 8/15/2025 • Limited coverage so that individuals need to have clinically severe coronary artery disease with documentation of ischemia on an imaging stress test and obstructive CAD that is not amendable to revascularization by PCI or CABG.
Hyperbaric and Topical Oxygen Therapies - (0053)	Updated	Important **changes** in coverage criteria/policy: • Changed from not covered to covered: avascular necrosis • Added not covered: penile glans necrosis
Plasma Brain Natriuretic Peptide in the Outpatient Setting - (0028)	Updated	Important **changes** in coverage criteria: • Expanded coverage for three new indications
Seat Lift Mechanisms, Patient Lifts and Standing Devices - (0343)	Updated	Important **changes** in coverage criteria: • Changed from not covered to covered for combination sit-to-stand frame/table systems. • Combined criteria for standing systems and removed criterion that devices be "nonpowered". • Removed "combination sit-to stand frame/table systems" and "electric, motorized, or powered standing devices" from the Not Medically Necessary Items list.

Treatment of Cutaneous and/or Deep Tissue Hemangioma, Port Wine Stain and Other Vascular Lesions - (0313)	Updated	**This is an existing policy that underwent annual review. Posting 5/15/25, Effective 8/15/25.** Minor **changes** in coverage criteria/policy: • Revised coverage statement to align with the benefit language (addition of verbiage related to "functional impairment"). • Due to this update a cascade change was made via addition of a new bullet point to address infantile hemangioma separately.
Cardiac Rehabilitation (Phase II Outpatient) - (0073)	Updated	• No change in coverage.
Cell-Based Therapy for Cardiac and Peripheral Arterial Disease - (0287)	Updated	• No change in coverage.
Donor Lymphocyte Infusion and Hematopoietic Progenitor Cell (HPC) Boost – (0261)	Updated	• No change in coverage.
Negative Pressure Wound Therapy/Vacuum Assisted Closure (VAC) for Nonhealing Wounds - (0064)	Updated	• No change in coverage.
Neuropsychological Testing – (EN0258)	Updated	• No change in coverage.
Peripheral Nerve Stimulation and Peripheral Nerve Field Stimulation – (0539)	Updated	• No change in coverage.
Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) – (0563)	Updated	• No change in coverage.

Tumor In Vitro Chemosensitivity and Chemoresistance Assays – (0203)	Updated	• No change in coverage.
Carotid Intima-Media Thickness Measurement – (0475)	Retired	This CP retired5/15/25. • There is one code in this CP and it is not implemented/managed.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Complex Lymphedema Therapy (Complete Decongestive Therapy) – (CPG 157)	Updated	• No change in coverage.
Strapping and Taping – (CPG 143)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Gastrointestinal Endoscopic Procedure Guidelines	Updated	Posted **2/1/2025**; Effective **5/1/2025**: Esophagogastroduodenoscopy (EGD): Important **changes** in coverage criteria. • Clinical changes which expand coverage: ○ Updated cardiac workup requirements prior to EGD for chest pain without typical gastroesophageal reflux disease symptoms. ○ Addition of indication for non-invasive testing for Barrett's esophagus. • Clinical change which limits coverage: ○ Clarified annual EGD surveillance of established diagnosis of eosinophilic esophagitis is for disease stability or progression of disease. • New section/guideline:

		○ Added new section with criteria for EGD in the setting of inflammatory bowel disease. Posted **3/14/2025**; Effective **5/1/2025**: Capsule Endoscopy: • No clinical changes.
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Posted **4/1/2025;** Effective **5/15/2025** No clinical changes: • Pediatric Abdomen Imaging • Preface to the Imaging Guidelines Posted **4/15/2025;** Effective **5/15/2025** Important **changes** in coverage criteria: • One guideline was updated with clinical changes which will expand coverage: ○ Musculoskeletal Imaging Posted **5/1/2025**; Effective **6/15/2025** Important **changes** in coverage criteria: • One guideline was updated with numerous clinical changes which will expand coverage: ○ Oncology Imaging Posted **5/15/2025;** Effective **6/15/2025** Important **changes** in coverage criteria: • Two guidelines were updated with clinical changes which will expand coverage: ○ Pediatric and Special Populations Oncology Imaging ○ Spine Imaging
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics (A008)	Updated	Effective 5/15/2025 **Added** Ciprofloxacin 0.3% / Fluocinolone 0.025% otic solution Authorized Generic for Otovel as a Not Covered Product, for all Employer Plans, effective 7/1/2025.

Cigna Healthcare Drug Coverage Policy	New, Updated, or Retired?	Comments
Amyloidosis – Acoramidis - (IP0728)	New	**Effective 5/15/2025** New policy.
Anticoagulants – Savaysa - (IP0034)	Updated	**Effective 5/1/2025** **Updated** the preferred product criteria requirements for Individual and Family Plans to also include the following exceptions: The patient is currently receiving Savaysa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]) and; The patient is currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery). **Venous Thromboembolism in an Acutely Ill Medical Patient, Prophylaxis. Updated** the statement to remove Bevyxxa, as it has been removed from the market.
Anticoagulants – Savaysa – (IP0034)	Updated	**Effective 5/15/2025** Added preferred product criteria for Employer Plans, effective 7/1/2025.
Antiemetic Therapy - (1705)	Updated	**Effective 5/15/2025** **Removed** Akynzeo injection, Aloxi injection, Cinvanti, injection, Emend injection, Sustol injection, Zofran solution, Zofran tablets, Zofran ODT and Zuplenz film medical necessity criteria from the policy.
Antiseizure Medications – Epidiolex - (IP0410)	Updated	**Effective: 5/1/2025** **Treatment-Refractory Seizures/Epilepsy [specific rare conditions]:** The conditions covered were expanded to include focal epilepsy.
Antiseizure Medications – Valtoco - (IP0105)	Updated	**Effective: 5/15/2025** **Preferred Product Table:** **Added** preferred product requirement criteria for Valtoco for Individual and Family Plans.

Attention Deficit Hyperactivity Disorder Non-Stimulant Medications - (IP0217)	Updated	**Effective: 5/15/2025** **Conditions Not Covered.** **Removed** "Long-Term Combination Therapy (for example, > 2 months) with atomoxetine (Strattera, generic) and Central Nervous System (CNS) Stimulants used for the Treatment of Attention Deficit/Hyperactivity Disorder (e.g., mixed amphetamine salts ER capsules [Adderall XR®, generic], methylphenidate ER tablets, methylphenidate immediate-release tablets)."
Brands with Bioequivalent Generics – (IP0011)	Updated	**Effective 5/1/2025** **Updated** Halog 0.1% cream to now read Halog 0.1% solution.
Chelating Agents – Iron Chelators - (IP0271)	Updated	**Effective: 5/1/2025** **Patients Currently Receiving an Oral Chelator**: The verbiage "Approve if the patient is benefiting from therapy, according to the prescriber." was updated to "Approve if the patient is benefiting from therapy, according to the prescriber." **Removed** deferiprone 500 mg and 1000 mg (three times daily) preferred product criteria (for Individual and Family Plans only). **Updated** Ferriprox 1000 mg tablets (two times daily) and solution preferred product criteria. **Updated** Ferriprox 500 mg and 1000 mg (three times daily) preferred product criteria.
Complement Inhibitors – Fabhalta – (IP0614)	Updated	**Effective: 5/15/2025** **Complement 3 Glomerulopathy:** This condition and criteria for approval were added to the policy.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	**Effective: 5/1/2025** **Added preferred product step requirement for the following products:** Azelex, Epiduo, Epiduo Forte, adapalene 0.1% swab, Differin cream, Differin gel, Differin lotion, clonidine extended-release tablet (authorized generic for Nexiclon XR), Nexiclon XR, Adlarity, Arakoda, Coartem, Krintafel, Opipza, topiramate 50 mg sprinkle capsules, Aspruzyo Sprinkle, clobetasol propionate 0.025% cream, Halog 0.1% cream, auranofin 3mg capsules, Omeclamox-Pak, Pylera, Talicia, Voquezna DualPak, Voquezna TriplePak, Finacea foam, Finacea gel, Emrosi, and Regranex (effective 6/1/2025).

		Updated preferred product step requirement for the following products: Fanapt, Basaglar KwikPen, Ridaura, and Zyflo. **Removed preferred product requirements for the following products:** Focinvez (effective 5/30/2025), Posfrea (effective 5/30/2025), Halog 0.1% Solution, and Zoryve 0.15% cream (effective 5/15/2025).
Eculizumab - (IP0549)	Updated	**Effective: 5/15/2025** **Bkemv, Epysqli (biosimilars to Soliris):** These agents were added to the policy; the same criteria apply as that for Soliris. **Generalized Myasthenia Gravis:** – Age requirement was changed to "≥ 6 years of age"; previously it was "≥18 years of age". – Criterion that addresses the Myasthenia Gravis Foundation of America classification and Myasthenia Gravis Activities of Daily Living score was changed such that this requirement only applies to patients ≥ 18 years of age. – Corticosteroid was added to the Note of examples of immunosuppressant therapies. **Updated HCPCS Coding** **Added:** Q5151 & Q5152 (Codes effective 4/1/2025)
Finerenone - (IP0314)	Updated	**Effective: 5/15/2025** **Preferred Product Table – Individual and Family Plans:** **Updated from** "Documented failure, contraindication, or intolerance to ONE of the following (A or B):" **to** "Patient has tried, or is currently taking ONE of the following (A or B):" **Updated** note **from** "A trial of another SGLT-2 inhibitor or SGLT-2 inhibitor-containing combination product also satisfies this requirement" **to** "A trial of, or if the patient is currently taking another SGLT-2 inhibitor or SGLT-2 inhibitor-containing combination product also satisfies this requirement."
Gonadotropin-Releasing Hormone Agonists – Lupron Depot - (IP0109)	Updated	**Effective: 5/15/2025** **Removed** Lupaneta Pack (obsolete). **Updated** the name of the policy **from** "Gonadotropin-Releasing Hormone Agonists – Injectable Long Acting Products for Non-Oncology and Non-infertility Indications" **to** "Gonadotropin-Releasing Hormone Agonists – Lupron Depot"

		Added criteria for Prostate Cancer, Breast Cancer, Head and Neck Cancer – Salivary Gland Tumors, Ovarian Cancer, including Fallopian Tube Cancer and Primary Peritoneal Cancer, Preservation of Ovarian Function/Fertility in Patients undergoing Chemotherapy, Prophylaxis or Treatment of Uterine Bleeding or Menstrual Suppression in Patients with Hematologic Malignancy, or Undergoing Cancer Treatment, or Prior to Bone Marrow/Stem Cell Transplantation (BMT/SCT), Uterine Cancer.
Graft-Versus-Host Disease – Ryoncil - (IP0732)	New	**Effective 5/15/2025** New policy.
Hematology – Gene Therapy – Casgevy (IP0615)	Updated	**Effective: 5/8/2025** **Sickle Cell Disease:** The requirement that the patient had at least four severe vaso-occlusive crises or events in the previous 2 years was revised such that the definitions of severe vaso-occlusive crises or events are now listed as examples (as a Note) rather than as a specific list as previously in the criteria. The qualifier "Prior to collection of cells for manufacturing" was removed from the requirement regarding screening for certain viruses and the word "Patient" was added. The new criterion now reads: "Patient screening is negative for ALL of the following…." **Transfusion-Dependent Beta-Thalassemia:** The qualifier "Prior to collection of cells for manufacturing" was removed from the requirement regarding screening for certain viruses and the word "Patient" was added. The new criterion now reads: "Patient screening is negative for ALL of the following...."
Hematology – Gene Therapy – Lyfgenia (IP0617)	Updated	**Effective: 5/8/2025** **Sickle Cell Disease:** The requirement that the patient had at least four severe vaso-occlusive crises or events in the previous 2 years was revised such that the definitions of severe vaso-occlusive crises or events are now listed as examples (as a Note) rather than as a specific list as previously in the criteria. The qualifier "Prior to collection of cells for manufacturing" was removed from the requirement regarding screening for certain viruses and the word "Patient" was added. The new criterion now reads: "Patient screening is negative for ALL of the following…".
Hematology – Gene Therapy – Zynteglo (IP0486)	Updated	**Effective: 5/8/2025** **Transfusion-Dependent Beta-Thalassemia:** The qualifier "Prior to collection of cells for manufacturing" was removed from the requirement regarding screening for certain viruses

		and the word "Patient" was added. The new criterion now reads: "Patient screening is negative for ALL of the following…".
Hematology – Reblozyl - (IP0115)	Updated	**Effective: 5/1/2025** **Retitled** coverage policy from "Hematology – Reblozyl for Non-Oncology Uses" to "Hematology – Reblozyl." **Added** criteria for coverage of Myelodysplastic Syndrome. **Added** criteria for coverage of Myelodysplastic/Myeloproliferative Neoplasm. **Added** dosing for Myelodysplastic Syndrome. **Added** dosing for Myelodysplastic/Myeloproliferative Neoplasm. **Added** documentation requirements as noted for coverage of Transfusion Dependent Beta-Thalassemia. **Added** documentation requirements as noted for coverage of Myelodysplastic Syndrome. **Added** documentation requirements as noted for coverage of Myelodysplastic/Myeloproliferative Neoplasm.
Hemophilia – Alhemo - (IP0730)	New	**Effective 5/15/2025** New policy.
Hemophilia – Hympavzi - (IP0731)	New	**Effective 5/15/2025** New policy.
Human Immunodeficiency Virus – Cabenuva - (IP0123)	Updated	**Effective: 5/1/2025** **Human Immunodeficiency Virus (HIV)-1, Treatment.** • **Added** documentation requirements (where noted) to medical necessity criteria.
Hyperparathyroidism – Parsabiv - (IP0718)	Updated	**Effective: 5/1/2025** **Policy Title:** **Updated from "**Etelcalcetide" to "Hyperparathyroidism – Parsabiv"

		Removed "Etelcalcetide (Parsabiv) is considered medically necessary for continued use when the following criteria are met: Initial criteria were met at start of therapy." **Secondary Hyperparathyroidism:** **Updated** criteria **from** "Individual is 18 years and older" **to "**Patient is ≥ 18 years of age." **Updated** criteria **from** "Treatment of secondary hyperparathyroidism (HPT) in individuals with chronic kidney disease (CKD)" **to** "Patient has chronic kidney disease." **Updated** criteria **from** "Individual is on hemodialysis" **to** "Patient is receiving hemodialysis." **Updated** criteria **from** "Documented failure/ inadequate response, contraindication per FDA label, not a candidate or intolerance to cinacalcet (Sensipar)" **to** "According to the prescriber, the patient has inadequate efficacy or significant intolerance to cinacalcet tablets." **Added** "Prior to initiation, dose increase, or re-initiation of Parsabiv, corrected serum calcium level is at or above the lower limit of normal as defined by the laboratory reference." **Added** "The medication being prescribed by or in consultation with a nephrologist or endocrinologist." **Added** "Patient with Parathyroid Carcinoma and Patient with Primary Hyperparathyroidism" to Parsabiv use considered not medically necessary.
Immunologicals – Tezspire – (IP0412)	Updated	**Effective: 5/15/2025** **For the following conditions considered not medically necessary:** **Chronic Obstructive Pulmonary Disease (COPD) and Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP),** trial results were updated. **For Concurrent use of Tezspire with another Monoclonal Antibody Therapy,** the examples of monoclonal antibody therapies were updated to also include Ebglyss and Nemluvio.
Infectious Disease – Prevymis for Individual and Family Plans - (IP0426)	Updated	**Effective: 5/1/2025** **Added** Prevymis oral pellets to coverage policy.
Inflammatory Conditions – Arcalyst - (IP0437)	Updated	**Effective 5/1/2025** **Cryopyrin-Associated Periodic Syndromes (CAPS).** For Initial Therapy, added "Documentation is provided that the patient has a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS)".

		Deficiency of Interleukin-1 Receptor Antagonist: Updated the statement "Genetic testing has confirmed a mutation in the *IL1RN* gene" to now read "Documentation is provided that the patient has had genetic testing that has confirmed bi-allelic pathogenic variants in the *IL1RN* gene." **Pericarditis.** Added documentation requirements confirming a history of at least three episodes of pericarditis, prior to starting treatment with Arcalyst. Updated Appendix.
Inflammatory Conditions – Cibinqo Prior Authorization Policy - (IP0677)	Updated	**Effective: 5/1/2025** **Atopic Dermatitis:** Ebglyss (lebrikizumab-lbkz subcutaneous injection) and Nemluvio (nemolizumab-ilto subcutaneous injection) were added to the note listing examples of systemic therapies. **Concurrent Use with a Biologic Immunomodulator:** Ebglyss and Nemluvio were also added as examples of biologic immunomodulators which are not allowed concurrently with Cibinqo. Updated Appendix
Inflammatory Conditions – Ilaris Prior Authorization Policy - IP0235	Updated	**Effective 5/1/2025** **Cryopyrin-Associated Periodic Syndromes:** The dosing requirement for a patient ≥ 15 kg and ≤ 40 mg was increased from 3 mg/kg every 8 weeks to allow up to 8 mg/kg every 4 weeks and for a patient > 40 kg from 150 mg every 8 weeks to allow up to 600 mg every 4 weeks. **Still's Disease, Adult-Onset**: The following Note was added "Adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (SJIA) are considered the same disease (Still's disease) but differ in age of onset. For a patient < 18 years of age, refer to the SIJA indication below." **Systemic Juvenile Idiopathic Arthritis**: The following Note was added "Systemic juvenile idiopathic arthritis (SJIA) and adult-onset Still's disease (AOSD) are considered the same disease (Still's disease) but differ in age of onset. For a patient ≥ 18 years of age, refer to AOSD indication above." Updated Appendix.

Inflammatory Conditions – Kineret Prior Authorization Policy - (IP0661)	Updated	**Effective: 5/1/2025** **Cryopyrin-Associated Periodic Syndromes:** An "allergist/immunologist" was added to the existing requirement that the medication is being prescribed by or in consultation with a rheumatologist, geneticist, or dermatologist. For a patient currently receiving Kineret, the examples of improvements in symptoms were moved from the criteria to a Note. **Deficiency of Interleukin-1 Receptor Antagonist:** The term "mutation" was rephrased to "biallelic pathogenic variants". For a patient currently receiving Kineret, the examples of improvements in symptoms were moved from the criteria to a Note. **Rheumatoid Arthritis:** The previous requirement "Patient experienced a beneficial clinical response when assessed by at least one objective measure" was reworded to "When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug)". The previous requirement "Patient experienced an improvement in at least one symptom…" was updated add "Compared with baseline (prior to initiating the requested drug)". **Still's Disease, Adult-Onset**: The following Note was added "Adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (SJIA) are considered the same disease (Still's disease) but differ in age of onset. For a patient < 18 years of age, refer to the SIJA indication below." **Systemic Juvenile Idiopathic Arthritis**: The following Note was added "Systemic juvenile idiopathic arthritis (SJIA) and adult-onset Still's disease (AOSD) are considered the same disease (Still's disease) but differ in age of onset. For a patient ≥ 18 years of age, refer to AOSD indication above."
Inflammatory Conditions – Rinvoq/Rinvoq LQ Prior Authorization Policy - (IP0682)	Updated	**Effective 5/1/2025** **Atopic Dermatitis:** Ebglyss (lebrikizumab-lbkz subcutaneous injection) and Nemluvio (nemolizumab-ilto subcutaneous injection) were added to the note listing examples of systemic therapies. **Concurrent Use with a Biologic Immunomodulator:** Ebglyss and Nemluvio were added as examples of biologic immunomodulators which are not allowed concurrently with Rinvoq and Rinvoq LQ.
Inflammatory Conditions – Adalimumab Products Preferred Specialty	Updated	**Effective 5/15/2025** **Tremfya Subcutaneous** was added to Appendix A as a Preferred Non-Adalimumab Product for Crohn's disease.

Management Policy for Individual and Family Plans – (PSM014)		
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans – (PSM003)	Updated	**Effective 5/15/2025** **Tremfya Subcutaneous** was added to Appendix A as a Preferred Non-Adalimumab Product for Crohn's disease.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists – (PSM013)	Updated	**Effective 5/15/2025** **Tremfya Subcutaneous** was added to Appendix A as a Preferred Non-Adalimumab Product for Crohn's disease.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan Prescription Drug Lists – (PSM011)	Updated	**Effective 5/15/2025** **Tremfya intravenous (IV)** was added as a Preferred Product for Crohn's Disease. Updated the Note to include a previous trial of Tremfya subcutaneous also counts.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy	Updated	**Effective 5/15/2025** **Tremfya subcutaneous (SC)** was added as a Preferred Product for Crohn's Disease. Criteria for Cimzia, Rinvoq, and Entyvio SC were updated to include Tremfya SC as a Preferred Product. For Entyvio SC, a previous trial of Tremfya intravenous also counts.

Prescription Drug Lists – (PSM017)		
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists – (PSM001)	Updated	**Effective 5/15/2025** **Tremfya subcutaneous (SC)** was added as a Preferred Product for Crohn's Disease. Criteria for Cimzia, Rinvoq, and Entyvio SC were updated to include Tremfya SC as a Preferred Product. For Entyvio SC, a previous trial of Tremfya intravenous also counts.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans – (PSM002)	Updated	**Effective 5/15/2025** **Tremfya subcutaneous (SC)** was added as a Preferred Product for Crohn's Disease. Criteria for Cimzia, Rinvoq, Omvoh SC, and Entyvio SC were updated to include Tremfya SC as a Preferred Product. For Omvoh SC and Entyvio SC, a previous trial of Tremfya intravenous also counts.
Inflammatory Conditions – Tremfya Intravenous Prior Authorization Policy – (IP0704)	Updated	**Effective 5/15/2025** • **Crohn's Disease:** This new condition of approval was added to the policy.
Inflammatory Conditions – Tremfya Subcutaneous Prior Authorization Policy – (IP0689)	Updated	**Effective 5/15/2025** • **Crohn's Disease:** This new condition of approval was added to the policy.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred	Updated	**Effective 5/15/2025** **Tremfya subcutaneous** was added to Appendix A as a Preferred Non-Ustekinumab Product for Crohn's disease.

Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists – (PSM021)		
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans – (PSM022)	Updated	**Effective 5/15/2025** • **Tremfya subcutaneous** was added to Appendix A as a Preferred Non-Ustekinumab Product for Crohn's disease.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Individual and Family Plans – (PSM023)	Updated	**Effective 5/15/2025** **Tremfya subcutaneous** was added to Appendix A as a Preferred Non-Ustekinumab Product for Crohn's disease.
Metabolic Disorders – Tiopronin - (IP0202)	Updated	**Effective 5/1/2025** Individual and Family Plans added to the policy. **Policy Title:** **Updated** from "Tiopronin" to "Metabolic Disorders – Tiopronin" **Added** Venxxiva, a branded generic tiopronin delayed-release product, to the Policy; the same criteria apply for all tiopronin products. **Preferred Product Table:** **Added** Thiola EC and Venxxiva to the Individual and Family Plans table.

Multiple Sclerosis – Ponvory - (IP0264)	Updated	**Effective 5/15/2025** **Added** preferred product requirements for Ponvory on Employer Plans, effective 7/1/2025.
Muscular Dystrophy – Deflazacort - (IP0131)	Updated	**Effective 5/15/2025** **Added** preferred product criteria for Emflaza tablets and oral suspension on Employer Plans, effective 7/1/2025.
Neurology – Edaravone Products - (IP0176)	Updated	**Effective: 5/1/2025** Radicava intravenous (IV) is available as generic edaravone IV. Generic edaravone IV was added to the policy with the same criteria as Radicava IV and brand name "Radicava" was changed to "edaravone" throughout the policy. The name of the policy was changed from Neurology – Radicava Products to Neurology – Edaravone Products. **Added** documentation requirements as noted in the medical necessity criteria. **Updated HCPCS Coding:** **Added** C9399 & J3490 with the following note: Considered Medically Necessary when used to report Edaravone ORS and medical necessity criteria outlined in this Coverage Policy are met.
Neurology – Qalsody - (IP0567)	Updated	**Effective: 5/1/2025** **Added** documentation requirements as noted in the medical necessity criteria.
Nitkimvo - (IP0722)	New	**Effective 5/15/2025** New Coverage policy.
Oncology – Jakafi - (IP0318)	Updated	**Effective: 5/15/2025** **Updated title from** "Jakafi (ruxolitinib) for Non-Oncology Indications " **to** "Oncology – Jakafi" **Graft versus Host Disease, Acute.** **Updated from** "Documentation of failure, contraindication, or intolerance **to** ONE systemic corticosteroid" to "Patient has tried one systemic corticosteroid" **Graft versus Host Disease, Chronic.**

		Updated from "Documentation of failure, contraindication, or intolerance to ONE conventional systemic treatment for grapft-versus-host-disease" **to** "Patient has tried one conventional systemic treatment for graft-versus-host disease.Note: Examples include systemic corticosteroids (methylprednisolone, prednisone), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib capsules, tablets, and oral solution), Rezurock (belumosudil tablet), Niktimvo (axatilimab-csfr intravenous infusion), pentostatin, rituximab, Orencia (abatacept intravenous infusion), hydroxychloroquine, and imatinib." **Added** criteria for: Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF, Polycythemia Vera, Accelerated or Blast Phase Myeloproliferative Neoplasm, Acute Lymphoblastic Leukemia, Atypical Chronic Myeloid Leukemia, Chronic Myelomonocytic Leukemia-2, Essential Thrombocythemia, Myeloid or Lymphoid Neoplasms, T-Cell Lymphoma.
Oncology (Injectable) – Proleukin - (IP0407)	Updated	**Effective: 5/1/2025** **Updated title from** "Proleukin (for Non-Oncology Uses)" **to** "Oncology (Injectable) – Proleukin" **Added** criteria for: (1) Cutaneous Melanoma, (2) Renal Cell Carcinoma
Oncology Medications - (1403)	Updated	**Effective: 5/15/2025** **Alunbrig.** **Updated** from "Patient is currently receiving Alunbrig" **to** "Patient has already been started on therapy with Alunbrig" **Boruzu.** **Added** criteria for Boruzu. **Lupron Depot.** **Removed** criteria for Lupron Depot.
Ophthalmology – Xipere - (IP0371)	Updated	**Effective: 5/15/2025** **Policy Title**: **Updated from** "Triamcinolone Acetonide Ophthalmic" **to** "Ophthalmology – Xipere." **Macular Edema Associated with Uveitis.** **Added** criteria "Patient is ≥ 18 years of age." **Removed** criteria "Individual has macular edema associated with non-infectious uveitis."

		Preferred Product Table: **Employer Plans and Individual and Family Plans** **Updated from** "ONLY the following: Triesence (triamcinolone acetonide)" **to** "ONE of the following: 1. Patient has tried Triesence ophthalmic injectable suspension; 2. Patient has already started on Xipere and requires Xipere to complete the course of treatment." **Removed** the statement "When coverage requires the use of preferred products, there is documentation of ONE of the following (A or B): A. The individual has had inadequate efficacy to the number of covered alternatives according to the table below; OR B. The individual has a contraindication according to FDA label, significant intolerance, or is not a candidate* for the covered alternatives according to the table below. *Note: Not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], other attributes/conditions, or is unable to administer and requires this dosage formulation." **Added** criteria "Concomitant Use with Another Intravitreal Corticosteroid" under use considered not medically necessary.
Opioid Therapy for Employer Group Benefit Plans - (IP0561)	Updated	**Effective 5/15/2025** **Preferred Product Requirement Table.** **Added** preferred product criteria for Percocet, effective 7/1/2025.
Pharmacy and Medical Prior Authorization - (1407)	Updated	**Effective: 5/1/2025** **Added** Individual and Family Plan product-specific medical necessity criteria: Azelex cream; clonidine 0.17 mg extended-release tablet; Nexiclon XR tablet; Adlarity transdermal system; donepezil and extended release memantine capsule; Namzaric; metronidazole 125 mg oral tablet; Arakoda tablet; Coartem tablet; Krintafel tablet; Cobenfy capsule; topiramate 50 mg oral sprinkle capsule; labetalol 400 mg oral tablet; nimodipine 60 mg/ 20 mL oral solution; Aspruzyo Sprinkle; prucalopride 1 mg, 2 mg oral tablet; hydrocortisone 2.5% topical solution; Soliqua; Xultophy; metformin immediate release 750 mg; dapagliflozin-metformin extended-release tablet; Invokamet; Invokamet XR; Segluromet; Gabarone 100 mg, 400 mg tablet; bismuth subcitrate 140 mg/ metronidazole 125 mg/ tetracycline 125 mg; Omeclamox-Pak; Pylera; Talicia; Voquezna Dual Pak; Voquezna Triple Pak; zileuton extended-release tablet; Zyflo tablet; baclofen 5 mg/ 5 mL oral solution; Fenopron 300 mg; Iopidine ophthalmic solution; Vtama cream; Finacea foam; Finacea gel; Trintellix **Updated** Individual and Family Plan product-specific medical necessity criteria: Gemtesa

Pharmacy and Medical Prior Authorization - (1407)	Updated	**Effective: 5/15/2025** **Updated** Individual and Family Plan product-specific medical necessity criteria: Posfrea, Focinvez, dapagliflozin_metformin extended-release tablet
Prenatal Vitamins - (IP0035)	Updated	**Effective: 5/1/2025** **Updated from** "There is documentation the individual has had an inadequate response, contraindication, or is intolerant to FIVE covered prescription prenatal vitamins" **to** "Approve for 1 year if patient meets **ONE** of the following: Patient has tried **ONE** generic prenatal vitamin formulation (for example, Prenatal Plus, Prenatal Vitamin + Low Iron, Prenate Mini, Prenatal-19, Vitafol); Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins." **Added** Individual and Family Plan to table
Pulmonary – Roflumilast for Individual and Family Plans - (IP0609)	Updated	**Effective: 5/1/2025** **Chronic Obstructive Pulmonary Disease.** The following changes were made: **Criteria were divided into Initial and Continuation criteria**. Initial approval duration was updated to 6 months if the patient meets the existing criteria. The requirement that the patient have severe COPD or very severe COPD, according to the prescriber was changed to require the patient have a forced expiratory volume in 1 second (FEV_1) < 50% predicted. **The requirement that the patient have a history of exacerbations** was updated to require the patient to have a history of two or more moderate COPD exacerbations or one or more severe COPD exacerbations, according to the prescriber. A Note was added to clarify that a moderate COPD exacerbation is an exacerbation that required treatment with a short-acting bronchodilator and a systemic corticosteroid. A severe COPD exacerbation is an exacerbation that required hospitalization or an Emergency Department visit. **The requirement that the patient has chronic bronchitis** was changed to apply to all patients. Previously, this requirement only applied to patients who were receiving inhaled therapy with a long-acting $beta_2$-agonist, a long-acting muscarinic antagonist, and an inhaled corticosteroid. **The Notes regarding other therapies tried** were updated to clarify that use of single-entity inhalers, as well as a combination inhaler fulfills the requirement. Previously, the Notes stated that a combination inhaler fulfilled the requirement. **Continuation criteria** were added to approve roflumilast (Daliresp, generic) for 1 year if the patient has tried generic roflumilast (if brand Daliresp is requested), if the patient continues to receive combination therapy with an inhaled long-acting $beta_2$-agonist and a long-acting muscarinic antagonist, and the patient has experienced a beneficial clinical

		response as defined by reduced COPD symptoms, exacerbations, hospitalizations, emergency department or urgent care visits, or improved lung function parameters.
Somatostatin Analogs – Octreotide Long-Acting Products - (IP0489)	Updated	**Effective: 5/15/2025** **Enterocutaneous Fistulas:** **Removed** "Preferred product criteria is met for the product as listed in the below table" **Meningioma:** **Removed** "Preferred product criteria is met for the product as listed in the below table" **Pancreatic Fistulas:** **Removed** "Preferred product criteria is met for the product as listed in the below table" **Thymoma and Thymic Carcinoma:** **Removed** "Preferred product criteria is met for the product as listed in the below table" **Merkel Cell Carcinoma:** The condition Merkel cell carcinoma was added under "Other Uses with Supportive Evidence." **Diarrhea Associated with Chemotherapy:** The condition diarrhea associated with chemotherapy was added under "Other Uses with Supportive Evidence." **Preferred Product Table – Employer Plans:** **Added** Diarrhea Associated with Chemotherapy and Merkel Cell Carcinoma
Somatostatin Analogs – Octreotide Immediate-Release Products - (IP0490)	Updated	**Effective: 5/15/2025** **Diarrhea Associated with Chemotherapy:** This condition and criteria for approval was added under "Other Uses with Supportive Evidence." **Preferred Product Table - Individual and Family Plans:** **Updated from** "Documentation that patient has tried the bioequivalent generic product, octreotide acetate immediate release, AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction" **to** "The patient has tried the bioequivalent generic product, octreotide acetate immediate release, AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives]

		between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction.”
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Updated	**Effective 5/15/2025** **Removed** Benicar, Benicar HCT, Celebrex, Diovan, Diovan HCT, Spriva Handihaler, and Vytorin from the policy, effective 7/1/2025. **Added** a new Ophthalmic Corticosteroids section, with Inveltys 1% ophthalmic suspension, Lotemax 0.5% ophthalmic ointment, and Lotemax SM 0.28% ophthalmic gel, effective 7/1/2025. **Added** Zoryve 0.15% cream, as a Step 3 Medication, to the Non-Steroidal Topical section.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) – (1801)	Updated	**Effective 5/15/2025** **Removed** Benicar, Benicar HCT, Caplyta, Celebrex, Diovan, Diovan HCT, Rexulti, Vraylar, and Vytorin from the policy, effective 7/1/2025. **Added** a new Ophthalmic Corticosteroids section, with Inveltys 1% ophthalmic suspension, Lotemax 0.5% ophthalmic ointment, and Lotemax SM 0.28% ophthalmic gel added as Step 3 Medications, effective 7/1/2025. **Added** Zoryve 0.15% cream, as a Step 3 Medication, to the Non-Steroidal Topical section.
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) – (1802)	Updated	**Effective 5/15/2025** **Removed** Celebrex from the policy, effective 7/1/2025. **Added** Zoryve 0.15% cream, as a Step 3 Medication, to the Non-Steroidal Topical section.
Testosterone (Oral, Topical, and Nasal) - (IP0350)	Updated	**Effective 5/15/2025** **Preferred Product Requirement Table.** **Added** preferred product criteria for Androgel on Employer Plans, effective 7/1/2025.
Transplantation – Grafapex - (IP0727)	New	**Effective 5/15/2025** New coverage policy.
Zokinvy - (IP0107)	Updated	**Effective 5/1/2025** **Added “Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information..” **Hutchinson-Gilford Progeria Syndrome:**

		Updated criteria **from** "Patient has a body surface area of ≥ 0.39 m^2" **to** "Documentation provided that the patient has a body surface area of ≥ 0.39 m^2." For confirmation by genetic testing, rephrased the term "mutation" to "variant".
Antiseizure Medications – Diacomit - (IP409)	Updated	**Effective: 5/15/2025** No change in coverage
Carglumic Acid - (IP0438)	Updated	**Effective: 5/1/2025** No change in coverage
Cystic Fibrosis – Bronchitol - (IP0126)	Updated	**Effective: 5/1/2025** No change in coverage
Hematology – Cablivi - (IP0161)	Updated	**Effective: 5/15/2025** No change in coverage
Hematology – Enjaymo - (IP0405)	Updated	**Effective: 5/1/2025** No change in coverage
Hematology – Pyrukynd - (IP451)	Updated	**Effective: 5/15/2025** No change in coverage
Hematology – Ryzplazim - (IP0382)	Updated	**Effective: 5/1/2025** No change in coverage
Hemophilia – Altuviiio - (IP0564)	Updated	**Effective: 5/15/2025** No change in coverage
Hemophilia – Factor IX Products – (IP0623)	Updated	**Effective: 5/15/2025** No change in coverage
Hemophilia – Factor VIII Products – (IP0618)	Updated	**Effective: 5/15/2025** No change in coverage
Hepatitis C – Sovaldi - (IP0157)	Updated	**Effective: 5/1/2025** No change in coverage
HIV – Sunlenca - (IP0546)	Updated	**Effective: 5/1/2025** No change in coverage

Hyperlipidemia – Omega-3 Fatty Acid Products - (IP0051)	Updated	**Effective: 5/1/2025** No change in coverage
Infectious Disease – Ivermectin Tablets - (IP0300)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy – (IP0652)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Cimzia Prior Authorization Policy – (IP0672)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy – (IP0675)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Kevzara Prior Authorization Policy – (IP0679)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Orencia Intravenous Prior Authorization Policy – (IP0664)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Spevigo Intravenous Prior Authorization Policy – (IP0501)	Updated	**Effective: 5/1/2025** No change in coverage
Inflammatory Conditions – Spevigo	Updated	**Effective: 5/1/2025** No change in coverage

Subcutaneous Prior Authorization Policy – (IP0649)		
Migraine – Nurtec ODT - (IP0147)	Updated	**Effective: 5/15/2025** No change in coverage
Migraine – Qulipta – (IP0377)	Updated	**Effective: 5/15/2025** No change in coverage
Migraine – Ubrelvy - (IP0148)	Updated	**Effective: 5/15/2025** No change in coverage
Nephrology – Filspari - (IP0565)	Updated	**Effective: 5/15/2025** No change in coverage
Neurology – Riluzole Products - (IP0258)	Updated	**Effective: 5/15/2025** No change in coverage
Oncology (Injectable) – Amtagvi - (IP0625)	Updated	**Effective: 5/1/2025** No change in coverage
Ophthamology – Durysta - (IP0218)	Updated	**Effective: 5/1/2025** No change in coverage
Ophthamology – iDose TR - (IP0619)	Updated	**Effective: 5/1/2025** No change in coverage
Ophthalmology – Tepezza - (IP0129)	Updated	**Effective: 5/1/2025** No change in coverage
Penicillamine - (IP0277)	Updated	**Effective: 5/1/2025** No change in coverage
Testosterone (Oral, Topical, and Nasal) - (IP0350)	Updated	**Effective: 5/1/2025** No change in coverage
Veregen - (IP0393)	Updated	**Effective: 5/1/2025** No change in coverage
Etelcalcetide – (1812)	Retired	**Effective 5/1/2025**

		• This policy will be replaced by IP0718 – Hyperparathyroidism – Parsabiv
Antimalarial Therapy - (P0101)	Retired	**Effective 5/1/2025** Arakoda, Coartem and Krintafel have been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
H. Pylori Infection Products – (IP0009)	Retired	**Effective 5/1/2025** All products (Omeclamox-Pax, Pylera, Talicia, Voquezna Dual Pak, and Voquezna Triple Pak) have been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
Topical Azelaic Acid Products – (IP0172)	Retired	**Effective 5/1/2025** All products (Azelex, Finacea foam, and Finacea gel) have been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
Topical Adapalene Products – (IP0181)	Retired	**Effective 5/1/2025** All products (adapalene 0.1% swab, Differin cream, Differin gel, Differin lotion, Epiduo, and Epiduo Forte) have been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
Clonidine Extended-Release – (IP0456)	Retired	**Effective 5/1/2025** All products (clonidine ER tablet and Nexiclon XR) have been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
Donepezil – (IP0502)	Retired	**Effective 5/1/2025** Adlarity has been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
Ranolazine – (IP0507)	Retired	**Effective 5/1/2025** Aspruzyo Sprinkle has been relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP
Vocabria – (IP0124)	Retired	**Effective 5/15/2025.**

CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies - Commercial	Updated	Updated prior authorization requirements are available on our website, CignaforHCP.Cigna.com. • For **May 30, 2025,** Cigna added 2 CPT, and 1 HCPCS codes to prior authorization. • For **May 30, 2025**, Cigna removed 89 CPT, and 8 HCPCS codes from prior authorization.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Procedure and Place of Service (R43)	Updated	
Virtual Care (R31)	Updated	
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for May 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**

Code Editing Policy and Guidelines	Updated	